

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1672

CERTIFICATE OF DEATH

Reg. Dist. No.

01676

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Huntingtown,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		f. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Moses A.</u> Middle <u>Brooks</u> Last		4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1914</u>
9. AGE (In years, lost birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Zora Fowler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Alena Brooks, Huntingtown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>593X</u> DUE TO <u>Bright's Disease (Hypertension c. u.)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with nephritis</u> - (c) <u>Colicoma</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-10</u> , 19 <u>58</u> , to <u>2-17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-17</u> , 19 <u>59</u> , and that death occurred at <u>6 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Devilla</u> M.D.		ADDRESS (Street, city or town, state) <u>St Leonard</u> DATE SIGNED <u>2/17/59</u>	
PHYSICIAN'S NAME (Type) <u>R DEVILLARREAL MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Feb 21, 59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Carrolls</u>		22d. LOCATION (City, town, or county) (State) <u>Barstow, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>		ADDRESS <u>P. E. Sewell</u>	
24a. REC'D BY REGISTRAR <u>Feb 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thane</u>	

CERTIFICATE OF DEATH

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1673

CERTIFICATE OF DEATH

Reg. Dist. No. 01677

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>—</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>T.</u> Last <u>Buckley</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1893</u>	9. AGE (In years lost birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 MRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Leroy G. Trath</u>				14. MOTHER'S MAIDEN NAME <u>Marionetta E. Harrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Calvert G. Buckley, Huntingtown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous of Pilonicium</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Cervix</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 weeks</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>58</u> , to <u>Feb 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ray C. Jett</u>				ADDRESS (Street, city or town, state) <u>Prince Frederick</u>			
PHYSICIAN'S NAME (Type) <u>RAY C. JETT</u>				DATE SIGNED <u>2/9/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 11, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Huntingtown Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Huntingtown - Calvert Co. - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. A. Harkness & Son - Mutual, Md.</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		JAN 15 1870		BALTIMORE, MD	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		DISEASE OR INJURY		PERIOD OF ILLNESS		MANNER OF DEATH	
JAN 25 1935		BALTIMORE, MD		HEART DISEASE		CORONARY ARTERY DISEASE		2 WEEKS		NATURAL	
TIME OF DEATH		HOURS		MINUTES		TEMPERATURE		PULSE		RESPIRATION	
10:00 AM		10		00		98.6		60		16	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF ASSISTANT		NAME OF ATTENDING		NAME OF WITNESS	
DR. J. H. HARRIS		BALTIMORE HOSPITAL		MISS J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF ASSISTANT		SIGNATURE OF ATTENDING		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF CERTIFICATE		PLACE OF CERTIFICATE		CAUSE OF CERTIFICATE		DISEASE OR INJURY		PERIOD OF ILLNESS		MANNER OF DEATH	
JAN 25 1935		BALTIMORE, MD		HEART DISEASE		CORONARY ARTERY DISEASE		2 WEEKS		NATURAL	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE.

THE MARYLAND DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION CONTAINED HEREIN.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01678

1674

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mutual</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Mutual</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>A.</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 26</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Un Employed</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Emmuel Jackson</u>			14. MOTHER'S MAIDEN NAME <u>Mary E. Jackson</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Marion Gantt</u> Address <u>Mutual, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Blind</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 6</u> , 19 <u>58</u> , to <u>Feb 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 11</u> , 19 <u>59</u> , and that death occurred at <u>5:15</u> A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James Gantt</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>2/14/59</u>			
PHYSICIAN'S NAME (Type) <u>P. E. JETT</u>				<u>PRINCE FREDERICK</u>			
22a. (BURIAL) CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brooks</u>		22d. LOCATION (City, town, or county) (State) <u>Mutual Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> ADDRESS <u>Prince Fred.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. RACE White		5. DATE OF DEATH April 4, 1968		6. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee	
7. CITY OF DEATH Memphis, Tennessee		8. COUNTY OF DEATH Shelby		9. STATE OF DEATH Tennessee		10. MARITAL STATUS Single		11. OCCUPATION Civil Rights Worker		12. CAUSE OF DEATH Gunshot wound	
13. MANNER OF DEATH Homicide		14. PLACE OF BIRTH Jackson, Mississippi		15. DATE OF BIRTH January 19, 1933		16. SEX OF BIRTH Male		17. RACE OF BIRTH White		18. MARITAL STATUS OF BIRTH Single	
19. OCCUPATION OF BIRTH Student		20. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		21. DATE OF DEATH April 4, 1968		22. SEX OF DEATH Male		23. RACE OF DEATH White		24. MARITAL STATUS OF DEATH Single	
25. OCCUPATION OF DEATH Civil Rights Worker		26. PLACE OF BIRTH Jackson, Mississippi		27. DATE OF BIRTH January 19, 1933		28. SEX OF BIRTH Male		29. RACE OF BIRTH White		30. MARITAL STATUS OF BIRTH Single	
31. OCCUPATION OF BIRTH Student		32. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		33. DATE OF DEATH April 4, 1968		34. SEX OF DEATH Male		35. RACE OF DEATH White		36. MARITAL STATUS OF DEATH Single	
37. OCCUPATION OF DEATH Civil Rights Worker		38. PLACE OF BIRTH Jackson, Mississippi		39. DATE OF BIRTH January 19, 1933		40. SEX OF BIRTH Male		41. RACE OF BIRTH White		42. MARITAL STATUS OF BIRTH Single	
43. OCCUPATION OF BIRTH Student		44. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		45. DATE OF DEATH April 4, 1968		46. SEX OF DEATH Male		47. RACE OF DEATH White		48. MARITAL STATUS OF DEATH Single	
49. OCCUPATION OF DEATH Civil Rights Worker		50. PLACE OF BIRTH Jackson, Mississippi		51. DATE OF BIRTH January 19, 1933		52. SEX OF BIRTH Male		53. RACE OF BIRTH White		54. MARITAL STATUS OF BIRTH Single	
55. OCCUPATION OF BIRTH Student		56. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		57. DATE OF DEATH April 4, 1968		58. SEX OF DEATH Male		59. RACE OF DEATH White		60. MARITAL STATUS OF DEATH Single	
61. OCCUPATION OF DEATH Civil Rights Worker		62. PLACE OF BIRTH Jackson, Mississippi		63. DATE OF BIRTH January 19, 1933		64. SEX OF BIRTH Male		65. RACE OF BIRTH White		66. MARITAL STATUS OF BIRTH Single	
67. OCCUPATION OF BIRTH Student		68. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		69. DATE OF DEATH April 4, 1968		70. SEX OF DEATH Male		71. RACE OF DEATH White		72. MARITAL STATUS OF DEATH Single	
73. OCCUPATION OF DEATH Civil Rights Worker		74. PLACE OF BIRTH Jackson, Mississippi		75. DATE OF BIRTH January 19, 1933		76. SEX OF BIRTH Male		77. RACE OF BIRTH White		78. MARITAL STATUS OF BIRTH Single	
79. OCCUPATION OF BIRTH Student		80. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		81. DATE OF DEATH April 4, 1968		82. SEX OF DEATH Male		83. RACE OF DEATH White		84. MARITAL STATUS OF DEATH Single	
85. OCCUPATION OF DEATH Civil Rights Worker		86. PLACE OF BIRTH Jackson, Mississippi		87. DATE OF BIRTH January 19, 1933		88. SEX OF BIRTH Male		89. RACE OF BIRTH White		90. MARITAL STATUS OF BIRTH Single	
91. OCCUPATION OF BIRTH Student		92. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		93. DATE OF DEATH April 4, 1968		94. SEX OF DEATH Male		95. RACE OF DEATH White		96. MARITAL STATUS OF DEATH Single	
97. OCCUPATION OF DEATH Civil Rights Worker		98. PLACE OF BIRTH Jackson, Mississippi		99. DATE OF BIRTH January 19, 1933		100. SEX OF BIRTH Male		101. RACE OF BIRTH White		102. MARITAL STATUS OF BIRTH Single	
103. OCCUPATION OF BIRTH Student		104. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		105. DATE OF DEATH April 4, 1968		106. SEX OF DEATH Male		107. RACE OF DEATH White		108. MARITAL STATUS OF DEATH Single	
109. OCCUPATION OF DEATH Civil Rights Worker		110. PLACE OF BIRTH Jackson, Mississippi		111. DATE OF BIRTH January 19, 1933		112. SEX OF BIRTH Male		113. RACE OF BIRTH White		114. MARITAL STATUS OF BIRTH Single	
115. OCCUPATION OF BIRTH Student		116. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		117. DATE OF DEATH April 4, 1968		118. SEX OF DEATH Male		119. RACE OF DEATH White		120. MARITAL STATUS OF DEATH Single	
121. OCCUPATION OF DEATH Civil Rights Worker		122. PLACE OF BIRTH Jackson, Mississippi		123. DATE OF BIRTH January 19, 1933		124. SEX OF BIRTH Male		125. RACE OF BIRTH White		126. MARITAL STATUS OF BIRTH Single	
127. OCCUPATION OF BIRTH Student		128. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		129. DATE OF DEATH April 4, 1968		130. SEX OF DEATH Male		131. RACE OF DEATH White		132. MARITAL STATUS OF DEATH Single	
133. OCCUPATION OF DEATH Civil Rights Worker		134. PLACE OF BIRTH Jackson, Mississippi		135. DATE OF BIRTH January 19, 1933		136. SEX OF BIRTH Male		137. RACE OF BIRTH White		138. MARITAL STATUS OF BIRTH Single	
139. OCCUPATION OF BIRTH Student		140. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		141. DATE OF DEATH April 4, 1968		142. SEX OF DEATH Male		143. RACE OF DEATH White		144. MARITAL STATUS OF DEATH Single	
145. OCCUPATION OF DEATH Civil Rights Worker		146. PLACE OF BIRTH Jackson, Mississippi		147. DATE OF BIRTH January 19, 1933		148. SEX OF BIRTH Male		149. RACE OF BIRTH White		150. MARITAL STATUS OF BIRTH Single	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1675

CERTIFICATE OF DEATH

Reg. Dist. No.

01679

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Owings</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cyne Shornthenia Long</u>				4. DATE OF DEATH Month Day Year <u>February 5 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 22, 1958</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>1 11 11</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Wilburn Long</u>				14. MOTHER'S MAIDEN NAME <u>Frances Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Frances Jones, Owings, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>491X</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/4/59</u> to <u>2/5/59</u> , that I last saw the deceased alive on <u>2/5/59</u> , and that death occurred at <u>9 a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Roberto de Villarreal</u> M.D.				ADDRESS (Street, city or town, State) <u>St. Leonard, Md.</u>			
DATE SIGNED <u>4/6/59</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Roberto de Villarreal</u>				<u>St. Leonard, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Feb 6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt Hope</u>		22d. LOCATION (City, town, or county) (State) <u>St Leonard Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Jewell</u> ADDRESS <u>Prince Frederick</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Wm L. Kline</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1676

CERTIFICATE OF DEATH

1680

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Fredrick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Fredrick Nursing Home</u>		d. STREET ADDRESS <u>08 X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>LUCY</u> Middle <u>ANN</u> Last <u>RADCLIFF</u>		4. DATE OF DEATH Month <u>February</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 17, 1883</u>
9. AGE (In years last birthday) yrs. <u>75</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp. Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>La Plata, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>R. Wood Murry</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Robey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-09-4967</u>	
17. INFORMANT <u>Mrs. Rosalee Quade (Niece) - Hughesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/26/59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 12, 1938</u> , to <u>Feb 4, 1959</u> , that I last saw the deceased alive on <u>Feb 2, 1959</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page C. Jett</u>		DATE SIGNED <u>Prince Frederick</u>	
PHYSICIAN'S NAME (Type) <u>Page C. Jett</u>		<u>PRINCE FREDERICK</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/7/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>La Plata, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>AREHART FUNERAL HOME, INC. * LA PLATA, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 9 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

CERTIFICATE OF DEATH

1918

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES H. HARRIS		Male		45		Jan 15, 1873		Baltimore, Md.		Carpenter		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. DISEASE OR INJURY		14. PRESENTING COMPLAINT		15. MEDICAL HISTORY		16. TREATMENT	
Jan 25, 1918		10:30 AM		Home		Heart Failure		Coronary Artery Disease		Chest Pain		Hypertension		None	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF DECEASED		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF MINISTER		22. SIGNATURE OF CLERGY		23. SIGNATURE OF CHURCH		24. SIGNATURE OF OTHER	
[Signature]		[Signatures]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
25. COUNTY		26. CITY		27. STATE		28. ZIP CODE		29. COUNTY		30. CITY		31. STATE		32. ZIP CODE	
Baltimore		Baltimore		Maryland		21201		Baltimore		Baltimore		Maryland		21201	

ORIGINAL

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1679 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg.-Dist. No.

01683

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> c. LENGTH OF STAY IN 1b <u>1</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cabot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Willow</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cabot Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mark</u> First <u>Mark</u> Middle <u>Schwartz</u> Last <u>Schwartz</u>		4. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/8/58</u>
9. AGE (In years last birthday) <u>4</u> Months <u>4</u> Days <u>4</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Schwartz</u>		14. MOTHER'S MAIDEN NAME <u>Sola E. Nicola (Nicola)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>5. Schwartz Hyattsville Md</u>	
17. INFORMANT <u>S. Schwartz Hyattsville Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory infection</u> 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Brought to Hospital and died in a few hrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H W Ward</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/13/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 16 '59</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01681

1677

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles St. Marys</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlotte Hall</u> 18x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard H. SOTHERON</u>		4. DATE OF DEATH Month Day Year <u>Feb 19 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 3, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levin J. Sotheron</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Canter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-18-1628</u>	
17. INFORMANT <u>N. S. Sotheron, Charlotte Hall, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melena</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of Stomach</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>7</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 10, 1959</u> , to <u>Feb 19, 1959</u> , that I last saw the deceased alive on <u>Feb 19, 1959</u> , and that death occurred at <u>3 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page J. Jett</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Prince Frederick</u>	
PHYSICIAN'S NAME (Type) <u>PAGE J. JETT</u>		M.D. <u>PRINCE FREDERICK</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>All Faith</u>		22d. LOCATION (City, town, or county) (State) <u>Charlotte Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE FEB 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G239 3-9-59 et

1678

CERTIFICATE OF DEATH

01682

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1 d. STREET ADDRESS <u>X Prince Frederick, Md</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cona</u> Middle <u>Stamper</u> Last <u>Stamper</u>		4. DATE OF DEATH Month <u>2</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Guanille, P.R.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henderson Hart</u>		14. MOTHER'S MAIDEN NAME <u>Eizabeth Hart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Miss. Aileen Stamper, Prince Frederick</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension c-d</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/1</u> , 19 <u>55</u> , to <u>2/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2/28</u> , 19 <u>55</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R de Villacirre</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>St Leonard</u> <u>3/1/59</u>	
PHYSICIAN'S NAME (Type) <u>R de VILLACIRRE M.D.</u>		<u>St Leonard</u>	
22a. BURIAL CREMATION, (REMOVAL) (Specify) <u>3-4, 59</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Blackwell</u>	22d. LOCATION (City, town, or county) (State) <u>Henderson N.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>		ADDRESS <u>Prince Frederick</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Farris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL (If attending physician: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

252 *W. J. G. Meijer*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 11, 12, See: Birth Cert. et

Reg. Dist. No.

01684

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland MD</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Russell Sylvester Thomas</u>		4. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/14/58</u>
9. AGE (In years last birthday) yrs. <u>8</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>13</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Prince Frederick, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathanial Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Virginia Thomas</u>		Address <u>Sunderland MD</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Upper respiratory disease</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed with mother at 9 AM</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2</u>	
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>2/13</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. City or town <u>Sunderland</u> County <u>Calvert</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H W Ward</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/13/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-14-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Edmund</u>		22d. LOCATION (City, town, or county) (State) <u>Sunderland MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>		ADDRESS <u>Prince Fred.</u>	
24a. REC'D BY REGISTRAR <u>FEB 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1681

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Republic</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Republic</i>	
3. NAME OF DECEASED (Type or print) <i>Chanta</i> First <i>Wall</i> Middle <i>Wallace</i> Last		4. DATE OF DEATH Month <i>2</i> Day <i>20</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/9/20</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE (In years and birth date) <i>38</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George Wall</i>		14. MOTHER'S MAIDEN NAME <i>Prosie Harrod</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>5-79-44610</i>	
17. INFORMANT <i>Walter Wall - Port Republic, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>instant use of left chest</i> DUE TO <i>Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (b) <i>Death</i> (c) <i>Death</i> DUE TO <i>Death</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>that man shot at Port Republic</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Shot by Highway</i>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Shot by Highway</i>		20c. TIME OF INJURY Month, Day, Year <i>2/20 1959</i>	
20d. INJURY OCCURRED While on work <input type="checkbox"/> Not while on work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Port Republic Calvert</i>	
20f. (City or town) <i>Port Republic</i>		20g. (County) <i>Calvert</i>	
20h. (State) <i>Md</i>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <i>H. Wall</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. Wall</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/23/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Bibleway Church Cem. Br. Frederick, Md.</i>		22d. LOCATION (City, town, or county) (State) <i>Br. Frederick, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leroy E. Perry-Huntington, Md.</i>		24a. REC'D BY REGISTRAR <i>Arthur L. House</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>		DATE <i>FEB 25 '59</i>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1087

NAME OF DECEASED _____		SEX _____		AGE _____	
PLACE OF BIRTH _____		OCCUPATION _____		DATE OF DEATH _____	
PLACE OF DEATH _____		TIME OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____		PRESENT ILLNESS _____	
SIGNS AND SYMPTOMS _____		PHYSICAL EXAMINATION _____		LABORATORY EXAMINATIONS _____	
POST-MORTEM FINDINGS _____		GROSS FINDINGS _____		MICROSCOPIC FINDINGS _____	
TOPOGRAPHIC ANATOMY _____		HISTOLOGY _____		RADIOLOGY _____	
OTHER FINDINGS _____		COMMENTS _____		SIGNATURE OF EXAMINER _____	
DATE OF EXAMINATION _____		PLACE OF EXAMINATION _____		OFFICIAL USE _____	

GEORGE K. VAUGHAN, M.D.
 BALTIMORE, MARYLAND

1682

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ST. MARY'S</u> b. COUNTY <u>18x-2</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Marys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MECHANICSVILLE, MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William B. Wallace</u> First Middle Last		4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salesman</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William B. Wallace</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E. Wallace</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Arthur L. Hume</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 26, 1927</u> to <u>Feb 16, 1927</u> , that I last saw the deceased alive on <u>Feb 16, 1927</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>W. Clarke Wallingley</u> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Lansel Grove Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Wallingley</u> ADDRESS <u>Severstown, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 3 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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